Making the Implicit Explicit: Designing and Implementing a Curriculum on Implicit Bias, Cultural Humility and Racism for Pediatric Residents, Faculty, and Interdisciplinary Care Teams

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Please text **22333** to **BCRPCHIEFS** to join poll everywhere
Please identify your role as a medical educator
(text in the letter corresponding to your response)

A. Program director
B. Assistant program director
C. Instructor in the residency
D. Instructor in the medical school
E. Program administrator
F. Chief resident
G. Resident
H. Other
Why do you do what you do?
What values drive your work?
Please provide a one word response
Framework

- Implicit bias increasingly recognized for its role in many disciplines, including medicine
- Lack of existing curricula to address the role of implicit bias in medicine

Motivated our institutions to create novel programs
Outline

• Introduction and background
• Implicit bias curriculum conceptual framework and examples
• Small group work:
  – Action planning
  – Curriculum evaluation
• Wrap-up
Workshop Objectives

1) Describe traditional cultural competency curricula and their limitations
2) Introduce the concept of implicit bias and its impact on medical decision-making
3) Provide a conceptual framework to develop curricula aimed at reducing the impact of implicit bias in medicine
   – Provide two examples of case-based curricula
   – Demonstrate the role of perspective-taking and the benefits of a case-based approach
   – Debrief lessons learned
4) Use the new conceptual framework to help develop an action plan for your own institution
5) Brainstorm methods of curriculum evaluation
Limitations of Traditional Cultural Competency Curricula
Changing Demographics

**U.S. population**

### 2000
- White: 72%
- Hispanic: 11%
- Black: 12%
- Asian/PI: 4%
- Native Am: 1%

### 2050
- White: 49%
- Hispanic: 24%
- Black: 14%
- Asian: 8%
- Other: 5%

2042
Changing Demographics

% increase by ethnicity

- Black: 71.3
- Asian: 212.9
- Other: 217.1
- Hispanic: 187.9
- White: 7.4
Sandra Williams, 46, Chicago, Illinois
Self-ID: biracial/“human being”
Census Boxes Checked: black
Kelly Williams II, 17, Dallas, Texas
Self-ID: African American and German/multiracial
Census Boxes Checked: black
Celeste Seda, 26, Brooklyn, New York
Self-ID: Dominican and Korean
Census boxes checked: Asian/some other race
Jordan Spencer, 18, Grand Prairie, Texas
Self-ID: black/biracial
Census box checked: black
Gender Roles

- Traditionally, males are the primary breadwinner and the head of the household.
- Females traditionally assume the caregiver and domestic role.
- The dynamics of every family are different.
  - Often there is an overlap in the gender roles in many white American families.
  - Some females work outside of the home and contribute equally to the finances, while some males may assist in childrearing and domestic duties.
Nonverbal Communication

- Gestures
  - Sometimes use frequent and large gestures to enhance verbal meaning.

- Personal Space
  - Some African Americans tend to consider that close proximity during conversation is preferable, as it expresses connectedness.
  - Among friends, tend to employ more physical touch than European Americans.
  - Touching African American men and women on the head may be considered insulting.
  - Muslim men and women do not exchange casual conversation or touching between the sexes.

- Eye Contact
  - Generally have a tendency to make direct eye contact when speaking, less so when listening.

- Time Orientation
  - Typically accustomed to working in linear time, but may be switch to cyclical or spiral time when in informal/comfortable settings.
  - Some tend to value relationships more than time.
  - May see lateness as a sign of disrespect.

Note: The terms "African American" and "Black" are often used interchangeably. The term "African American" is the preferred term in the United States.
Chinese

China is located in East Asia. It is bordered by 14 countries including: Afghanistan, Bhutan, Burma, India, Kazakhstan, North Korea, Kyrgyzstan, Laos, Mongolia, Nepal, Pakistan, Russia, Tajikistan, and Vietnam. China is currently engaged in border disputes with India, Malaysia, Philippines, Russia (recently resolved 2004), Taiwan and Vietnam (LOC China 2006). Throughout history, China has invaded and occupied neighboring regions, and has also been the object of attempted foreign invasion and occupation. This historically made China cautious when dealing with outsiders. This is evident by the construction of one of China's most famous landmarks: The Great Wall- a series of connecting walls and forts, built between 589 A.D. - 1643 A.D., that span (officially) 6,000km and (unofficially) up to 50,000 km. The history of China is one of the earliest civilizations (beginning some 5-6,000 years ago) that has contributed to the global community in a variety of areas (art, technology, education, trade, culture, philosophy, etc.) for millennia.

The Chinese population is a largely homogenous society with 91.6% of the citizens belonging to the Han ethnicity. China is the fourth largest country in the world and has the largest population with more than 1.35 billion people (World Factbook China 2014).

The Chinese Diaspora can be found all over the globe including other Asian countries, North America, Europe, Latin America and the Caribbean. There is evidence of Chinese on the North American continent before Columbus. The Chinese were some of the first immigrants from Asia to the United States. Chinese immigrants have arrived in the U.S. in three major waves.

The first major wave of Chinese immigration was after the Gold Rush in Western states (1849-1882) (Wang 2000). Most of these people were young, male, contracted workers for the mining industry. They worked hard to improve their position and that of their family. The second wave of Chinese immigrants came in the early 20th century (1910-1920) (Hines 1987). The majority of these people were seeking escape from political turmoil in China. The Chinese Exclusion Act of 1882 was lifted in 1943, allowing Chinese immigration to become easier. Many people came to work in steel mills and on railroads. The third wave of Chinese came in the mid-20th century (1960-1980). This wave was called the New Immigration and most of these people were from Hong Kong and Taiwan (Wang 2000).
<table>
<thead>
<tr>
<th>Early Models</th>
<th>Recent Model</th>
<th>Newer Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>cross-cultural</td>
<td>cultural competence</td>
<td>CLAS/quality</td>
</tr>
<tr>
<td>immigrants, refugees, LEP, non-Western</td>
<td>all people of color (those affected by disparities)</td>
<td>everyone</td>
</tr>
<tr>
<td>culture, language</td>
<td>prejudice, stereotyping, social determinants of health</td>
<td>safety, disparities</td>
</tr>
<tr>
<td>interpersonal interactions</td>
<td>health care organizations</td>
<td>systems, communities</td>
</tr>
</tbody>
</table>

**Source:** The Role & Relationship of Cultural Competence & Patient-Centeredness in Health Care Quality (Mary Catherine Beach, Somnath Saha, & Lisa A. Cooper, October 2006, The Commonwealth Fund)
How Do We Upgrade the Curriculum?
What is Implicit Bias?

• **Bias**: prejudice in favor of or against one thing, person, or group compared with another, usually in a way considered to be unfair.

**Explicit Bias**
- Conscious
- Self-reported
- Decline in incidence overtime

**Implicit Bias**
- Inherent to human psychology
- Affect interpretation of the world around us
- Exist for a wide range of topics
- Learned stereotypes and prejudices
- Automatic and unconscious
- Difficult to change
Implicit Bias in Medicine: The Role of the Dual Processes Theory

**System 1**
- Fast
- Unconscious
- Automatic
- Everyday Decisions
- Error prone

**System 2**
- Slow
- Conscious
- Effortful
- Complex Decisions
- Reliable

Graphic source: http://upfrontanalytics.com/market-research-system-1-vs-system-2-decision-making/
Role of Implicit Bias in Medicine

• All members of a medical interaction come bearing biases
• MDs have implicit bias$^{1,2,3,4,5}$
• Pediatricians have implicit bias$^{2,6}$
• Pediatricians’ implicit biases impact medical care and patient outcomes and can lead to inequities$^6$
• Patients perceive less patient-centered care when seen by physicians with high levels of implicit bias$^{7,8}$

## What Can We Do About Implicit Bias?

<table>
<thead>
<tr>
<th>Motivation</th>
<th>Information</th>
<th>Emotion</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal motivation to respond without bias</td>
<td>Understand the psychological basis of bias</td>
<td>Enhancing provider confidence</td>
<td>Increasing perspective-taking and empathy</td>
</tr>
<tr>
<td>Understand the historical context of racism</td>
<td>Regulating emotional responses</td>
<td>Building partnerships with patients</td>
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**Provider Judgment**
Individuated impressions and patient-centered clinical care

Theoretical Framework to Tangible Curricula
Duke Curriculum Logistics

• 3-hour, interactive workshop
• Offered twice/year
• Facilitated by 2 faculty members
• Includes 8-12 residents pulled from elective
  – Includes all levels
  – Some residents do not attend until 3rd year
  – Only attend once during training
• Asked to read “The Silent Curriculum” prior to workshop
Theoretical Framework in Practice

Motivation
- Internal motivation to respond without bias

Information
- Understand the psychological basis of bias
- Understand the historical context of racism

Emotion
- Enhancing provider confidence
- Regulating emotional responses

Skills
- Increasing perspective-taking and empathy
- Building partnerships with patients

Provider Judgment
- Individuated impressions and patient-centered clinical care

<table>
<thead>
<tr>
<th>Implicit Association Test</th>
<th>Didactic instruction</th>
<th>Create a safe space for self-reflection</th>
<th>Communication skills practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussion of Health Disparities and role of physician bias</td>
<td>“Replaying” cases from personal experience</td>
<td>Prepared cases with different perspectives</td>
<td></td>
</tr>
</tbody>
</table>

Duke Curriculum Content

1. “Crossing the Line” Ice Breaker
2. Discussion of changing demographics in the U.S.
3. Introduction to implicit bias
   - Participants take Implicit Association Test in workshop
4. Overview of Health Disparities and role of physician bias
5. Discussion of prepared case where bias impacted care
6. Summary of tools for providing patient-centered care as a means to mitigate bias
7. Video module from Worlds Apart Series with discussion
8. Small group case discussions from trainees’ personal experience
Layers of Diversity
More than race & ethnicity

In reflecting on your self-identity, which layer does your most important diversity characteristic come from? *(poll everywhere)*

1. Personality (red)
2. Characteristic you were born with (green)
3. Experiential (grey)
4. Organizational (purple)
In reflecting on your self-identity, which layer does your 2\textsuperscript{nd} most important diversity characteristic come from? (poll everywhere)

1. Personality (red)
2. Characteristic you were born with (green)
3. Experiential (grey)
4. Organizational (purple)
Case Discussions: 3 types

• Prepared case of patient with asthma
  – 3 perspectives: neutral, provider, and mother
  – Conflict results as the unintended response to well-intentioned behavior

• Video Case and discussion: Justine Chitsena from World’s Apart Series
  – Mother as “in-between” generation

• Pair and share discussion of real cases from participant’s experiences
  – Most valuable based on feedback; hardest to facilitate
Brief Overview of Boston Medical Center Curriculum
Boston Medical Center (BMC) Health Equity Rounds Logistics

• One-hour, interactive morning conference
• Offered quarterly
• Led by residents and selected faculty moderator(s)
• Interdisciplinary and interdepartmental
• Complementary to intern racial justice training workshop
Goals

BMC Health Equity Rounds

• Increase participants' awareness of personal implicit bias and structural bias, including its impact on patient care

• Challenge participants to consider their personal biases when working with patients
Objectives

BMC Health Equity Rounds

• Explore the psychological basis of bias
• Self-reflect on personal bias through cases
• Examine the historical context of structural bias
• Examine how structural bias impacts personal interactions and institutional systems
• Identify and apply strategies to mitigate institutional, interpersonal, and structural bias
Theoretical Framework in Practice

Motivation
- Internal motivation to respond without bias

Information
- Understand the psychological basis of bias
- Understand the historical context of racism

Emotion
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Skills
- Increasing perspective-taking and empathy
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Provider Judgment
- Individuated impressions and patient-centered clinical care

Health Equity Rounds
- Provide evidence for adverse impact of bias
- Motivate attention by using real cases
- Didactic instruction
- Create a safe space for self-reflection
- End on a high note: Emphasize concrete next steps
- Provide opportunity for low-stakes skill building

Example Case Presentation
You are in the ED…

- It is 11:00 PM on a Monday in early Spring
- 11 year old boy
- Name: Martin Hernandez
- Chief complaint: abdominal pain
- Vital signs: T 37.5, HR 88, RR 20, BP 98/58
- BMI: 98th percentile
You walk into the room...

- Martin is smiling and watching TV
- There is a doughnut box on the exam table and white powdered sugar on his face
- He is lying down and rubbing his abdomen in a circular motion
- He is with his mother Gloria
- She is overweight
- She is tapping her right leg and holding his hand
- She is speaking to Martin in Spanish and English
- They greet you in English
Reflection
History of Present Illness

• Characterization of abdominal pain
  – Started 3 days ago; epigastric, burning
  – Decreased appetite, but normal PO intake
  – No nausea or vomiting; daily stooling, no melena
Additional History

• Mom is worried he eats too fast
• Mom cannot control the amount of junk food he eats when he is home with his brother while she is at work
• Mom is specifically concerned about cancer due to family history of maternal great aunt with gastric cancer, maternal aunt with breast cancer, and maternal grandfather with prostate cancer
• He has not attended school since abdominal pain started
Social History

• Born in Boston
• Parents born in DR; living in Boston for 15 years
• Family is bilingual
• Parents divorced, but in a friendly relationship
• Mostly lives with mom and mom’s boyfriend
• Mom works as retail clerk M-F from 10am-8pm
• Home alone with brother after school
• 6th grade: good grades and attendance record
Physical Exam

• Heart & Lung: normal
• Abdomen: soft with mild tenderness in the epigastric area; no hepatomegaly, and no masses
• Skin: acanthosis nigricans on the nape of neck and axilla
Perspective Taking Exercise

Imagine yourself in this mother’s shoes
Case Wrap-up

• At the first ED visit, the patient was given a “GI cocktail” and discharged with plan to trial famotidine and follow-up with PMD
• Within the next 10 days, the patient returned to the ED twice and additionally visits his PCP
• He was ultimately referred to GI clinic where profound weight loss was noted and abdominal imaging revealed a large mass, which was later confirmed to be malignancy
Small Group/Individual Reflection

• With the guided imagery and the case unfolding over time, how does who you pictured evolve?
• How did the perspective-taking exercises make you feel?

• Identify the implicit biases that may have impacted the case
• What are the risk factors for discrimination or bias?
• What bothered you about this case?
What can we take away from these experiences?
Shared Challenges

• Choosing appropriate cases
• Getting people to talk about implicit bias rather than medical aspects of case
• Addressing the needs of different learners:
  – Those who need evidence
  – Those who “grew up” in a time where race-blindness = anti-racism
• Talking about race and bias is uncomfortable
Shared Lessons Learned

• Role of the moderator(s)
  – Guiding discussion
  – Every session will be different; requires flexibility

• Trainees are ahead of faculty

• Current events may influence discussion

• Approach with curiosity and not judgment

• Format drives what you are able to accomplish
Action Planning

• Small group breakout
  – Group 1
    • No existing curriculum on implicit bias
    • OR have a curriculum, but want to workshop something new
  – Group 2
    • Have existing implicit bias curriculum

• Use worksheets provided
Theoretical Framework

**Motivation**
- Internal motivation to respond without bias

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**Provider Judgment**
- Individuated impressions and patient-centered clinical care

Building an Assessment
Using Kirkpatrick’s model to assess medical curricula

- **Result**: Did the training impact processes or patient outcomes?
- **Transfer**: Did participants change behavior in the workplace as a result of the training?
- **Learning**: Did the training result in an increase in knowledge, skills, or attitudes?
- **Reaction**: How did the participants react to the training?
Duke Assessment Experience

• Most existing assessment tools are aligned with knowledge-based curriculum
  – specific cultural norms and values
• Tool designed to measure resident preparedness and skillfulness to deliver cross-cultural care
  – Relies on self-assessment
  – Inherently flawed given that most bias is unconscious
Duke Assessment Experience

• Pre- and post-workshop assessment of 52 trainees
  – 92% found the workshop useful.
  – At baseline, 92% of trainees felt prepared to care for patients from different cultures; did not change significantly after the workshop
  – Increased skillfulness in assessing the patient’s understanding of illness, identifying cultural customs that might affect clinical care and negotiating a realistic treatment plan.

• Raises question of “post-pre-” survey: “in hindsight, prior to the workshop, how prepared were you...”
BMC Assessment Experience

NEGATIVE

angry
anxious
tense
sad
bored

POSITIVE

excited
enthusiastic
pleased
content
calm
relaxed
fatigued
Small Group Assessment Exercise

What are the barriers? Can we collaborate?

How do we get to Level 1?

Did participants change behavior in the workplace as a result of the training?

Did the training result in an increase in knowledge, skills or attitudes?

Did the training impact processes or patient outcomes?

How did the participants react to the training?

Using Kirkpatrick’s Model
Workshop Objectives

1) Describe traditional cultural competency curricula and its potential drawbacks
2) Introduce the concept of implicit bias and its impact on medical decision-making
3) Provide a conceptual framework to develop curricula aimed at reducing the impact of implicit bias in medicine
   – Provide two examples of case-based curricula
   – Demonstrate the role of perspective-taking and the benefits of a case-based approach
   – Debrief lessons learned
4) Use the new conceptual framework to help develop an action plan for your own institution
5) Brainstorm methods of curriculum evaluation
Conclusions & Wrap Up

• Take home materials
  – Cases and discussion questions
  – Guided imagery instructions
  – Glossary
  – Key readings

• Contact Information
  – Creating a network for sharing implicit bias curricula
Thank you


References


Schwartz M, O’Neal Chambliss H, Brownell KD, Blair SN, Billington C. Weight Bias among Health Professionals Specializing in Obesity. *Obesity Research.* 2003;11(9)1033-9.


